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8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. **2013-154**

13 **BRITTON LEE WHALEN**
10086 N. Heather Drive
14 Fresno, CA 93720
Registered Nurse License No. 748595

A C C U S A T I O N

15 Respondent.

16 Complainant alleges:

17 **PARTIES**

18 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her
19 official capacity as the Executive Officer of the Board of Registered Nursing ("Board"),
20 Department of Consumer Affairs.

21 **Registered Nurse License**

22 2. On or about April 6, 2009, the Board issued Registered Nurse License Number
23 748595 to Britton Lee Whalen ("Respondent"). The registered nurse license was in full force and
24 effect at all times relevant to the charges brought herein and will expire on December 31, 2012,
25 unless renewed.

26 **STATUTORY PROVISIONS**

27 3. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent
28 part, that the Board may discipline any licensee, including a licensee holding a temporary or an

1 inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of
2 the Nursing Practice Act.

3 4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not
4 deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or
5 to render a decision imposing discipline on the license. Under Code section 2811, subdivision
6 (b), the Board may renew an expired license at any time within eight years after the expiration.

7 5. Code section 2761 states, in pertinent part:

8 The board may take disciplinary action against a certified or licensed
9 nurse or deny an application for a certificate or license for any of the following:

10 (a) Unprofessional conduct....

11 6. Code section 2762 states, in pertinent part:

12 In addition to other acts constituting unprofessional conduct within the
13 meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a
14 person licensed under this chapter to do any of the following:

15 (a) Obtain or possess in violation of law, or prescribe, or except as
16 directed by a licensed physician and surgeon, dentist, or podiatrist administer to
17 himself or herself, or furnish or administer to another, any controlled substance as
18 defined in Division 10 (commencing with Section 11000) of the Health and Safety
19 Code or any dangerous drug or dangerous device as defined in Section 4022.

20 (e) Falsify, or make grossly incorrect, grossly inconsistent, or
21 unintelligible entries in any hospital, patient, or other record pertaining to the
22 substances described in subdivision (a) of this section.

23 7. Code section 4060 states, in pertinent part:

24 No person shall possess any controlled substance, except that furnished to
25 a person upon the prescription of a physician, dentist, podiatrist, or veterinarian.

26 8. Health and Safety Code section 11173, subdivision (a) states:

27 No person shall obtain or attempt to obtain controlled substances, or
28 procure or attempt to procure the administration of or prescription for controlled
substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by
concealment of a material fact.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the
administrative law judge to direct a licentiate found to have committed a violation or violations of

1 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
2 enforcement of the case.

3 **10. CONTROLLED SUBSTANCE**

4 "Dilaudid" is a trade name for hydromorphone, a Schedule II controlled substance
5 pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug
6 pursuant to Code section 4022, in that under federal and state law it requires a prescription.

7 **FIRST CAUSE FOR DISCIPLINE**

8 **(Obtain and Possess Controlled Substances in Violation of Law)**

9 11. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on
10 the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that
11 between August 18, 2010, and October 24, 2010, while on duty as a registered nurse at Kaweah
12 Delta Hospital, Visalia, California, Respondent committed the following acts:

13 a. Respondent obtained the controlled substance Dilaudid by fraud, deceit,
14 misrepresentation, or subterfuge for his own use by taking the drugs from hospital supplies in
15 violation of Health and Safety Code section 11173, subdivision (a).

16 b. Respondent possessed the controlled substance Dilaudid without lawful authority in
17 violation of Code section 4022.

18 **SECOND CAUSE FOR DISCIPLINE**

19 **(Falsify, or Make Grossly Incorrect Entries in Patient/Hospital Records)**

20 12. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on
21 the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that
22 while on duty as a registered nurse at Kaweah Delta Hospital, Visalia, California, Respondent
23 falsified, made grossly incorrect, grossly inconsistent, or unintelligible entries in the following
24 patient/hospital records:

25 **Patient A**

26 a. On September 4, 2010, at 4:40 hours, Respondent withdrew a 2 mg vial of
27 Hydromorphone from the Pyxis system for this patient; however, Respondent failed to document
28 the administration or wastage of any portion of the Hydromorphone in the patient's medication

1 administration record or otherwise account for the disposition of the 2 mg of Hydromorphone in
2 any hospital record.

3 **Patient B**

4 b. On October 19, 2010, at 02:34 hours, Respondent withdrew a 2 mg vial of
5 Hydromorphone from the Pyxis system for this patient; however, Respondent failed to document
6 the administration or wastage of any portion of the Hydromorphone in the patient's medication
7 administration record or otherwise account for the disposition of the 2 mg of Hydromorphone in
8 any hospital record.

9 c. On October 24, 2010, at 03:31 hours, Respondent withdrew a 2 mg vial of
10 Hydromorphone from the Pyxis system for this patient; however, Respondent failed to document
11 the administration or wastage of any portion of the Hydromorphone in the patient's medication
12 administration record or otherwise account for the disposition of the 2 mg of Hydromorphone in
13 any hospital record.

14 **Patient D**

15 d. On August 24, 2010, at 06:18 hours, Respondent withdrew a 1 mg vial of
16 Hydromorphone from the Pyxis system for this patient. Respondent failed to document the
17 administration of any portion of the Hydromorphone in the patient's medication administration
18 record. Respondent wasted .05 mg of the drug but failed to account for the disposition of the
19 remaining .05 mg of Hydromorphone in any hospital record.

20 **Patient E**

21 e. On August 18, 2010, at 00:41 hours, Respondent withdrew a 2 mg vial of
22 Hydromorphone from the Pyxis system for this patient; however, Respondent failed to document
23 the administration or wastage of any portion of the Hydromorphone in the patient's medication
24 administration record or otherwise account for the disposition of the 2 mg of Hydromorphone in
25 any hospital record.

26 **Patient F**

27 f. On September 28, 2010, at 05:05 hours, Respondent withdrew a 2 mg vial of
28 Hydromorphone from the Pyxis system for this patient; however, Respondent failed to document

1 the administration or wastage of any portion of the Hydromorphone in the patient's medication
2 administration record or otherwise account for the disposition of the 2 mg of Hydromorphone in
3 any hospital record.

4 g. On September 28, 2010, at 05:56 hours, Respondent withdrew a 1 mg vial of
5 Hydromorphone from the Pyxis system for this patient. Respondent failed to document the
6 administration of any portion of the Hydromorphone in the patient's medication administration
7 record. Respondent wasted .05 mg of the drug but failed to account for the disposition of the
8 remaining .05 mg of Hydromorphone in any hospital record.

9 **Patient H**

10 e. On October 21, 2010, at 04:54 hours, Respondent withdrew a 2 mg vial of
11 Hydromorphone from the Pyxis system for this patient; however, Respondent failed to document
12 the administration or wastage of any portion of the Hydromorphone in the patient's medication
13 administration record or otherwise account for the disposition of the 2 mg of Hydromorphone in
14 any hospital record.

15 **PRAYER**

16 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
17 and that following the hearing, the Board of Registered Nursing issue a decision:

- 18 1. Revoking or suspending Registered Nurse License Number 748595, issued to Britton
19 Lee Whalen;
- 20 2. Ordering Britton Lee Whalen to pay the Board of Registered Nursing the reasonable
21 costs of the investigation and enforcement of this case, pursuant to Business and Professions
22 Code section 125.3; and,
- 23 3. Taking such other and further action as deemed necessary and proper.

24 DATED: *September 5, 2012*

Louise R. Bailey
LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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